MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

December 18, 2008
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Thursday, December 18, 2008 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, Vernon Malone, and William Purcell and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Jean Farmer Butterfield, Carolyn Justus, and Fred Steen. Advisory members Representatives Van Braxton and William Brisson were also present.

Denise Harb, Ben Popkin, Shawn Parker, Gann Watson, Susan Barham, Joyce Jones and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. Senator Nesbitt suggested that the LOC wait to issue its final report to the General Assembly until after the new administration is formed, and until the new Secretary was in place. He asked for a motion to approve the minutes from the November 18, 2008 meeting. The motion was made by Representative Braxton and the minutes were approved.

Dan Jones, Area Director from Onslow-Carteret Behavioral Healthcare (OCBHS) addressed statistical facts about Onslow County, with 4 military instillations, and Carteret County. (See Attachment No. 2) He said to provide stability within the community, both counties had Walk-In Clinics with providers housed in Carteret County. Mr. Jones said OCBHS is proud of its Crisis Intervention program, and that OCBHS is working closely with the local hospitals to try to attain crisis beds.

Mr. Jones noted the increase in the number of military in Onslow County, and expressed concern for the veterans returning from the war, because the transition from a combat zone to a community zone can be very traumatic. He said individuals in the military often refuse to seek needed services. He said OCBHS is working with the Federal government on a program that deals with returning combat veterans to their families. He said that once the program is stabilized, OCBHS would like to replicate it for civilians. Mr. Jones also said the OCBHS board created a position on the board for an active duty military person, and a position had been created at OCBHS that dealt with veterans, spouses, and children. He asked the LOC to carefully consider how it might be able to assist those in the military.

Next, Dr. Dana Hagele and Dr. Lisa Amaya-Jackson, Co Directors of the NC Child Treatment program, explained a pilot mental health initiative in the northeastern part of the State. (See Attachment No. 3a and No. 3b) The program helps children and adolescents who have

experienced serious psychological trauma and loss. Dr. Hagele gave statistics and explained the types of traumas addressed in the program (typically, sexual abuse, domestic violence exposure, and bereavement). She cited examples of the adverse outcomes that can be expected from untreated childhood trauma such as poor physical health in adulthood, risky behaviors, developmental delays and cognitive difficulties.

Dr. Hagele then described the key aspects of the treatment model. The program uses a public health approach to mental health using highly-trained licensed clinicians trained in treatment proven to work with excellent outcomes. In most cases treatment lasts no longer than 4 months. She said the pilot project covered 28 counties and was initially funded for $1.8 million for 3 years, ending in June 2009. Dr. Hagele said that since the grant funding was ending shortly, an annual recurring legislative appropriation of $2 million dollars was needed to continue the program.

Members of the LOC were impressed by the presentation and suggested that the program could make a significant impact on the dropout rate in the school systems. Members said they would be interested in hearing from families and licensed clinicians providing the treatment.

Senator Nesbitt reviewed several items on the MHDDSA System Indicators sheet for November that is prepared monthly by staff. (See Attachment No. 4) He pointed out the savings in the Community Support program since July of 2007, and that the amount of money going into enhanced services was going up, as it should, indicating that there was a better mix of services and more skilled services getting to people. Members voiced concern over the number of days an individual must wait to enter an ADATC facility. Flo Stein, Chief of Community Policy Management for the Division of MHDDSAS, said that one recommendation was to provide pre-treatment services to those individuals while they are waiting to enter a facility. Representative Insko pointed out that the Institute of Medicine would have a comprehensive report ready in January on substance abuse which would provide an overview of the needs of the substance abuse system.

Next, Leza Wainwright, Co-Director of the Division of MH/DD/SAS, gave an overview of residential options for persons with developmental disabilities. (See Attachment No. 5) She said that in 2007, 19,000 people with developmental disabilities were served in the public sector. Currently, 10,000 are being treated through the CAP-MR/DD waiver program. She added that 7,000 live at home or on their own. Ms. Wainwright reviewed a chart showing the types of facilities available and the number of beds in those facilities. She was asked to provide a chart showing an estimate of where all of the people with DD were living.

Next, Carol Donin from DHHS State Operated Services presented an overview of the three State operated developmental centers, Murdoch, Caswell, and Riddle. (See Attachment No. 6) Ms. Donin provided general data about the residents and explained the special programs offered at the centers including the PATH program, BART, the STARS program, and the MR/MI program. Also, she reviewed the centers' research, education and training programs. Ms. Donin noted that there is significant collaboration with other State agencies, particularly with the psychiatric hospitals, and she explained the responsibilities of the DD Consumer Advisory Committee. Regarding staff turnover, Ms. Donin said the staff turnover rate had been low and stable, but

pointed out that a large number of the workforce had worked for 25-30 years and would be retiring in the next few years.

After lunch, Ms. Wainwright returned to address community ICF/MR facilities, DD Group Homes, and Adult Care Homes serving DD consumers. (See Attachment No. 5) She said there are 328 ICF/MR facilities across the State with 2,737 total beds. She said that before a facility can be designated as ICF/MR, it must first be a group home for the developmentally disabled licensed under rules of the Commission on MH/DD/SAS. The difference between an ICF/MR and the State DD centers is that the people residing in the DD centers have 100% inclusive care of their physical health care needs met at the State level, while those in an ICF/MR have their physical health and dental health care needs met by other providers in the community.

Next, Ms. Wainwright said that DD group homes are specifically licensed to serve individuals with intellectual/developmental disabilities. She provided statistical data for adults and children, and reviewed restrictions and the rates. Ms. Wainwright was asked to provide the average client cost for the State and community ICF/MRs, the DD group homes, for CAP services, and for those not living in these settings.

Regarding Adult Care Homes, Ms. Wainwright explained that there are 2 types of homes, Family Care homes with 2-6 beds, and those with 7 or more beds. Members expressed concern that the smaller homes might not be monitored as closely as the larger homes, and that there should be a greater emphasis placed on accountability. Ms. Wainwright then provided statistical information regarding the Adult Care and Family Care Homes with 7 or more beds. She was asked again to provide the cost for the DD population being served in these settings.

Next, Rose Burnette, Tiered Waiver Project Manager for the Division of MH/DD/SAS, gave a brief summary of the details of the CAP-MR/DD supports waiver and the comprehensive waiver. (See Attachment No. 7) She said the 2 new waivers, implemented on November 1, 2008, were approved initially by the federal CMS for 3 years. She said that although each waiver has an annual per-consumer service dollar cap ($17,500 for the supports waiver and $135,000 for the comprehensive waiver), a consumer is not automatically entitled to the maximum service level; instead, services and supports for both waivers are based on the needs of the individual which is outlined in their Person Centered Plan. Ms. Burnette went over the objectives that DHHS hopes to meet, including making modifications to the residential service component to include reducing the size of the homes. She also discussed the transition to the new waivers, and said that once the transition of current consumers to the new waivers is complete, DHHS will release the new CAP-MR/DD tier 1 slots that were funded by the General Assembly in this past year's budget.

Ms. Burnette then explained the Home Supports service. Home Supports is a new service and is only provided within the Comprehensive Waiver. It provides habilitation and personal care services. Ms. Burnette reviewed the five levels of care available, which are based on a consumer's intensity of need. The Home Supports service is a per diem service and is paid at a daily rate; therefore, a consumer can chose to have Home Supports or another service but not on the same day. However, she listed several services that could be received outside of the home along with Home Supports. Ms. Burnette said it was decided to allow an additional 60 days to implement the waiver so people could have time to decide whether to use Home Supports or an

outside provider to provide services. She also reviewed the new guidelines for children under the new waivers.

Dr. Michael Lancaster, Co-Director of the Division of MH/DD/SAS, provided a brief update on the State psychiatric hospitals as follows:

- **Broughton Hospital**: In February, Broughton hospital plans to submit a reapplication to the Joint Commission for accreditation. Also, Broughton has been designated to pilot the new Smoking Sensation program which would be developed over the next 12 months; the campus will be smoke-free for both patients and employees.

- **Cherry Hospital**: Director Dr. Jack St. Clair submitted his resignation effective December 31, and Carl Fitch of the Compass Group would act as the interim hospital director. Dr. James Osberg, head of State Operated Services, will be the conduit for information related to State services since Mr. Fitch is not a State employee.

- **Central Regional Hospital**: Central Regional Hospital (which consists of two campuses, Butner and Raleigh) is in jeopardy of losing Medicaid funds, but Dr. Lancaster noted that DHSR had completed its review and that DHSR intends to recommend to the federal CMS Atlanta office that the jeopardy be removed. DHSR had submitted a report with a number of condition level deficiencies, and standard level deficiencies on both campuses. DMH submitted a plan for addressing the issues, and DHSR will return by mid February for a review. Also, a Violence Reduction program had been initiated in the facilities to reduce seclusions and restraints across the State.

There being no further business, the meeting adjourned at 3:10 PM.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant